The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **https://www.dhrm.virginia.gov**. For general definitions of common terms, such as **allowed amount, balance billing, coinsurance, copayment, deductible, provider**, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-642-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/person or **$600**/family for in-network providers.	Generally you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive services, office visits, prescription drugs, out-patient surgery, hospital stays, behavioral health, and routine vision and hearing.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes. Dental **deductible** **$50**/person, **$100**/two people, or **$150**/family. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,500**/person or **$3,000**/family for in-network provider.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Dental, routine vision and hearing and hearing, **premiums, balance-billed** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Will you pay less if you use a network provider?	**Yes. See www.anthem.com or call 1-800-552-2682 for a list of network providers.**	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might

Important Questions	Answers	Why This Matters:
		receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a **referral.**

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
	Specialist visit	$40/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
	Preventive care/**screening**/immunization	No charge	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for. **Balance billing** may occur for out-of-network services.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% **coinsurance** after **deductible**	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance** after **deductible**	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	A Health Services Review is required. **Balance billing** may occur for out-of-network services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **COVA Care Drug List**	Tier 1 - Typically Generic drugs	$15/**copay** (retail); $30/**copay** (home delivery)	$15/**copay** (retail); $30/**copay** (home delivery)	Retail up to 34 day supply; home delivery up to 90 day supply. Mandatory generic program. If you or your doctor requests a brand named drug when a generic is available, you pay the brand **copay** plus the difference between the allowable charge for the generic and the brand named drug.
	Tier 2 - Typically Preferred / Brand drugs	$30/ **copay** (retail); $60/**copay** (home delivery)	$30/ **copay** (retail); $60/**copay** (home delivery)	
	Tier 3 - Typically Non-Preferred / **Specialty drugs**	$45/**copay** (retail); $90/**copay** (home delivery)	$45/**copay** (retail); $90/**copay** (home delivery)	
	Tier 4 - Typically **Specialty drugs**	$55/**copay** (retail); $110/**copay** (home delivery)	$55/**copay** (retail); $110/**copay** (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
	Physician/surgeon fees	$25 PCP; $40 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
If you need immediate medical attention	**Emergency room care**	$150/visit	Covered as in-network	Copay waived if admitted. **Balance billing** may occur for out-of-network services.
	Emergency medical transportation	20% **coinsurance** after **deductible**	Covered as in-network	**Balance billing** may occur for out-of-network services.
	Urgent care	$25 PCP; $40 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300/stay	Covered as in-network less a 25% reduction in	**Balance billing** may occur for out-of-network services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			the amount paid by your **plan**.	
	Physician/surgeon fee	No charge	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit $25/visit Other Outpatient $125/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services. Employee Assistance Program (EAP) covered at no charge with up to 4 visits per incident per **plan** year.
	Inpatient services	$300/stay	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	
If you are pregnant	Office visits	$25 PCP; $40 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) **Balance billing** may occur for out-of-network services.
	Childbirth/delivery professional services	No charge	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	
	Childbirth/delivery facility services	$300/stay	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	
If you need help recovering or have other special health needs	**Home health care**	No charge	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	90 visits/benefit period. **Balance billing** may occur for out-of-network services.
	Rehabilitation services	$25 PCP; $35 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	$15 copay for physical therapy services only. **Balance billing** may occur for out-of-network services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$25 PCP; $35 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	
	Skilled nursing care	No charge	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	180 days/benefit period. **Balance billing** may occur for out-of-network services.
	Durable medical equipment	20% **coinsurance** after **deductible**	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
	Hospice service	No charge	Covered as in-network less a 25% reduction in the amount paid by your **plan**.	**Balance billing** may occur for out-of-network services.
If your child needs dental or eye care	Eye exam	$15 **copay** **$0 once OOP is met**	$30 allowance	**Balance billing** may occur for out-of-network services.
	Glasses	$0 copay; formulary* for frames. $20 **copay ($0 copay once OOP is met)** for polycarbonate standard single vision lenses.	$80 allowance for frames. $50 allowance for polycarbonate standard single vision lenses.	*Members will need to select their covered frames from a specific selection (formulary).
	Dental check-up	No charge	Covered as in-network	**Balance billing** may occur for out-of-network services.

* For more information about limitations and exceptions, see the plan or policy document at www.dhrm.virginia.gov.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbs.com
- Chiropractic care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Dental care (adult)
- Hearing aids
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.dhrm.virginia.gov.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) copayment	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$410
Coinsurance	$209
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$979**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) copayment	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,135
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,862**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$40
Hospital (facility) copayment	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$835
Coinsurance	$164
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,299**

Note: These numbers assume the patient does not participate in the **plan's** wellness program. If you participate in the **plan's** wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-552-2682.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-800-552-2682

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-800-552-2682 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-800-552-2682.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-800-552-2682 :

Bassa (Bàsɔ̀ɔ̀ Wùdù): Mì dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùŭn bó pídyi. Bɛ́ m̀ ké wudu-ziìn-nyɔ̀ dò gbo wùdù kɛ, dá 1-800-552-2682.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য 1-800-552-2682 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် 1-800-552-2682 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 1-800-552-2682。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl 1-800-552-2682.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u 1-800-552-2682.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-800-552-2682 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 1-800-552-2682.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie 1-800-552-2682.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο 1-800-552-2682.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો 1-800-552-2682.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-800-552-2682.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें 1-800-552-2682 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau 1-800-552-2682.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ 1-800-552-2682.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti 1-800-552-2682.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi 1-800-552-2682.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero 1-800-552-2682

Language Access Services:

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、1-800-552-2682　にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ 1-800-552-2682 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-800-552-2682.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-800-552-2682 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-800-552-2682.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíílnih 1-800-552-2682.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-800-552-2682

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-800-552-2682 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 1-800-552-2682 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-552-2682.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para 1-800-552-2682.

Language Access Services:

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-800-552-2682 ਤੇ ਕਾਲ ਕਰੋ।

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Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili 1-800-552-2682.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite 1-800-552-2682.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang 1-800-552-2682.

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Language Access Services:

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe 1-800-552-2682.

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